PUBLIC REPORT OF THE MARKET CONDUCT EXAMINATION

OF THE CLAIMS PRACTICES OF THE

# LIFE INSURANCE COMPANY OF NORTH AMERICA
# NAIC # 65498 CDI # 1513-1

**AS OF MARCH 31, 2003**

## STATE OF CALIFORNIA

## DEPARTMENT OF INSURANCE

## MARKET CONDUCT DIVISION

## FIELD CLAIMS BUREAU

**TABLE OF CONTENTS**

**DEPARTMENT OF INSURANCE**
Consumer Services and Market Conduct Branch
Field Claims Bureau, 11th Floor
300 South Spring Street
Los Angeles, CA 90013

July 16, 2004

The Honorable John Garamendi
Insurance Commissioner
State of California
45 Fremont Street
San Francisco, California 94105

Honorable Commissioner:

Pursuant to instructions, and under the authority granted under Part 2, Chapter 1, Article 4, Sections 730, 733, 736, and Article 6.5, Section 790.04 of the California Insurance Code; and Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a) of the California Code of Regulations, an examination was made of the claims practices and procedures in California of:

**Life Insurance Company of North America**

**NAIC #65498**

Hereinafter referred to as the Company.

This report is made available for public inspection and is published on the California Department of Insurance web site (www.insurance.ca.gov) pursuant to California Insurance Code section 12938.

## SCOPE OF THE EXAMINATION

The examination covered the claims handling practices of the aforementioned Company during the period April 1, 2002 through March 31, 2003. The examination was made to discover, in general, if these and other operating procedures of the Company conform with the contractual obligations in the policy forms, to provisions of the California Insurance Code (CIC), the California Code of Regulations (CCR), the California Vehicle Code (CVC) and/or case law. This report contains only alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. Any alleged violations of other relevant laws which may result from this examination will be included in a separate report which will remain confidential subject to the provisions of CIC Section 735.5.

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the Company for use in California including any documentation maintained by the Company in support of positions or interpretations of fair claims settlement practices.

2. A review of the application of such guidelines, procedures, and forms, by means of an examination of claims files and related records.

3. A review of consumer complaints received by the California Department of Insurance (CDI) in the most recent year prior to the start of the examination.

The examination was conducted primarily at the offices of the Life Insurance Company of North America in Pittsburgh, Pennsylvania.

The report is written in a "report by exception" format. The report does not present a comprehensive overview of the subject insurer's practices. The report contains only a summary of pertinent information about the lines of business examined and details of the non-compliant or problematic activities or results that were discovered during the course of the examination along with the insurer's proposals for correcting the deficiencies. When a violation is discovered that results in an underpayment to the claimant, the insurer corrects the underpayment and the additional amount paid is identified as a recovery in this report. All unacceptable or non-compliant activities may not have been discovered, however, and a failure to identify, comment on or criticize activities does not constitute acceptance of such activities.

Any alleged violations identified in this report and any criticisms of practices have not undergone a formal administrative or judicial process.

## CLAIM SAMPLE REVIEWED AND OVERVIEW OF FINDINGS

The examiners reviewed files drawn from the category of Closed Claims for the period April 1, 2002 through March 31, 2003, commonly referred to as the "review period." The examiners reviewed 254 claims files. The examiners cited 56 claims handling violations of the Fair Claims Settlement Practices Regulations and/or California Insurance Code Section 790.03 within the scope of this report. Further details with respect to the files reviewed and alleged violations are provided in the following tables and summaries.

| **Life Insurance Company of North America** | | | |
|---|---|---|---|
| **CATEGORY** | **CLAIMS FOR REVIEW PERIOD** | **REVIEWED** | **CITATIONS** |
| Disability (Short Term & Long Term) | 827 | 63 | 13 |
| Waiver of Premium | 45 | 22 | 6 |
| Blanket Accidental Death & Dismemberment | 1226 | 65 | 12 |
| Life | 457 | 35 | 2 |
| Participant Accident | 2946 | 69 | 23 |
| **TOTALS** | 5501 | 254 | 56 |

# TABLE OF TOTAL CITATIONS

| Citation | Description | Life Insurance Company of North America |
|---|---|---|
| CCR §2695.5(b) | The Company failed to respond to communications within 15 calendar days. | 15 |
| CIC §790.03(h)(5) | The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. | 9 |
| CCR §2695.11(b) | The Company failed to provide an explanation of benefits. | 7 |
| CIC §790.03(h)(3) | The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. | 4 |
| CCR §2695.3(a) | The Company's claim file failed to contain all documents, notes and work papers that pertain to the claim. | 5 |
| CCR §2695.3(b)(2) | The Company failed to record in the file the date the Company received, date the Company processed and date the Company transmitted and/or mailed [certain or particular] every relevant document in the file. | 4 |
| CCR §2695.4(a) | The Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy. | 4 |
| CCR §2695.7(b)(3) | The Company failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance. | 3 |
| CCR §2695.7(b)(1) | The Company failed to provide the written basis for the denial of the claim. | 2 |
| CCR §2695.5(d) | The Company's claims agent failed to immediately transmit notice of claim to the insurer. | 1 |
| CCR §2695.7(c)(1) | The Company failed to provide written notice of the need for additional time every 30 calendar days. | 1 |
| CCR §2695.7(g) | The Company attempted to settle a claim by making a settlement offer that was unreasonably low. | 1 |
| **Total Citations** | | 56 |

## SUMMARY OF CRITICISMS, INSURER COMPLIANCE ACTIONS AND TOTAL RECOVERIES

The following is a brief summary of the criticisms that were developed during the course of this examination related to the violations alleged in this report. This report contains only alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. In response to each criticism, the Company is required to identify remedial or corrective action that has been or will be taken to correct the deficiency. Regardless of the remedial actions taken or proposed by the Company, it is the Company's obligation to ensure that compliance is achieved. As a result of the examination, the total amount of money returned to claimants within the scope of this report was $12,160.61.

**1. The Company failed to respond to communications within 15 calendar days.** In fifteen instances, the Company failed to respond to communications with 15 calendar days. The Department alleges these acts to be in violation of CCR § 2695.5(b).

**Summary of Company Response:** The Company has acknowledged each violation and herein responds as follows: "The Company's procedure is to comply with the 15 day notice requirement and make every effort to do so. In these instances, claim personnel inadvertently did not acknowledge the claim or correspondence timely. The Company will review the compliance guidelines with claim personnel and continue the review of this requirement in our regular monthly compliance audits for our STD and LTD lines of business. With respect to our life and accident business, the claim office turnaround time standards were amended to 10 business days in June 2003. This will assist in reducing undue delays and enable us to adhere to the 15 day requirement. We will continue to monitor adherence to these requirements. With respect to our Third Party Administrators, we will reinforce California's requirements and continue to include these requirements in future audit criteria."

**2. The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.** In nine instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonable clear. The Department alleges these acts to be in violation of CIC §790.03(h)(5).

**Summary of Company Response:** The Company has acknowledged each violation and herein responds as follows: "The Company respectfully submits that we have adopted policies and procedures which set-forth "best practice" standards designed to comply with California requirements, including Insurance Code requirements. We provide California Fair Claims Practices training and material to all claims representatives. Additionally, we provide CA Fair Claims Practices Manuals to our TPA's and obtain the yearly certifications acknowledging that they understand these requirements. We acknowledge and regret the delays that were experienced, with nine claims processed by and through our Third Party Administrator and one claim file processed by Company. The Company agrees to re-emphasize the importance of proper claims handling and continue to audit to ensure timely benefit payments are made."

The Department determined that eight (8) of the nine (9) alleged violations were instances wherein Company, by and through its Third Party Administrator, failed to reimburse medical claims to policyholders and/or Providers as soon as practical. The remaining alleged violation

was an instance wherein Company's claims personnel failed to process the claim timely. The Company has agreed to re-emphasize the importance of proper claims handling to claims staff during the monthly compliance audits. Further, Company will continue to audit each Third Party Administrator to ensure that timely payments are issued. All outstanding payments have been reimbursed to the appropriate policyholder and/or Provider, including interest, as a result of this examination.

**3. The Company failed to provide an explanation of benefits.** In seven instances, the Company failed to provide to the claimant an explanation of benefits including the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits. The Department alleges these acts to be in violation of CCR §2695.11(b).

**Summary of Company Response:** The Company has acknowledged each violation and herein responds as follows: "The Company will continue to review and evaluate our STD/LTD approval/denial letters for compliance and make appropriate adjustments. We will continue to perform audits to ensure that proper information is provided to claimants. Additionally, we are in the process of instituting a new system which streamlines our current claims processes. The Case Manager will have a number of required fields that they will be unable to by-pass when setting up a claim. One of the fields prompts the Case Manager to acknowledge whether or not WOP is applicable, and will prompt management with the appropriate action to be taken once the acknowledgement of the coverage is made. We believe that this new process will adequately address any deficiencies regarding the WOP claims, however, we will continue to monitor the WOP claims to ensure compliance."

**4. The Company failed to properly document claim files.** In five instances, the Company's files failed to contain all documents, notes and work papers. The Department alleges these acts to be in violation of CCR §2695.3(a).

**Summary of Company Response:** The Company has acknowledged each violation and herein responds as follows: "The Company will review the file documentation guidelines with claim personnel and will continue to review for proper file documentation in future audits. We believe these to be isolated instances and not indicative of our normal processing standards."

**5. The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims.** In four instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Department alleges these acts to be in violation of CIC §790.03(h)(3).

**Summary of Company Response:** The Company has acknowledged each violation and herein responds as follows: "The Company advises that although its procedure is to comply with this regulation, in these instances, actions were not taken within the required time frame. The Company considers these to be isolated occurrences and not indicative of our normal processing standards. The appropriate claim personnel will be advised that affirmation or denial of coverage must be issued within the required time for compliance. We will review compliance

guidelines with claim personnel and continue to monitor the staff's progress through our regular compliance audits."

**6.** **The Company failed to record claim data in the file.** In four instances, the Company failed to record the date the Company received, date(s) the Company processed and date the Company transmitted or mailed every relevant document in the file. The Department alleges these acts to be in violation of CCR §2695.3(b)(2).

**Summary of Company Response:** The Company has acknowledged each violation and herein responds as follows: "The Company advises that it is normal procedure to date stamp all documents as they are received and these instances were an unintentional oversight. Company procedures regarding date stamping of all claim documents have been reinforced with appropriate personnel and we have added this requirement to our monthly compliance audits. We will also reinforce this requirement with our Third Party Administrators."

**7.** **The Company failed to disclose all policy provisions.** In four instances, the Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy. The Department alleges these acts to be in violation of CCR §2695.4(a).

**Summary of Company Response:** The Company has acknowledged each violation and herein responds as follows: "The Company is currently reviewing and evaluating STD approval/denial letters for compliance and making adjustments. We will continue ongoing audits to ensure proper information is provided to claimants. We will also review this with our Third Party Administrators and include this in future audit criteria."

**8.** **The Company failed to advise the claimant that he/she may have the claim denial reviewed by the California Department of Insurance.** In three instances, the Company failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he/she may have the matter reviewed by the California Department of Insurance. The Department alleges these acts to be in violation of CCR §2695.7(b)(3).

**Summary of Company Response:** The Company has acknowledged each violation and herein responds as follows: "This was an inadvertent oversight by our claim personnel. Our denial letters do have the appropriate referral information. In addition, denied claims are part of the monthly claim audit. With respect to Third Party Administrators, we are re-confirming this requirement and asking for them to up-date all denial correspondence, where applicable."

**9.** **The Company failed to provide written basis for the denial of the claim.** In two instances, the Company failed to provide written basis for the denial of the claim. The Department alleges this act to be in violation of CCR §2695.7(b)(1).

**Summary of Company Response:** The Company has acknowledged each violation and herein responds as follows: "The Company acknowledges these errors and will

reinforce with Third Party Administrators that each must include the factual basis and/or the specific policy provision, condition or exclusion for this denial in their denial correspondence."

**10. The Company's claims agent failed to immediately transmit notice of claim to the insurer.** In one instance, the Company's claim agent failed to immediately transmit notice of claim to the insurer. The Department alleges this act to be in violation of CCR §2695.5(d).

**Summary of Company Response:** The Company acknowledges this violation and herein responds as follows: "The Company has acknowledged this isolated occurrence and will reinforce this requirement to the affected Agent and Third Party Administrator, to immediately transmit a notice of claim."

**11. The Company failed to provide written notice of the need for additional time every 30 calendar days.** In one instance, the Company failed to provide written notice of the need for additional time every 30 calendar days. The Department alleges this act to be in violation of CCR §2695.7(c)(1).

**Summary of Company Response:** The Company acknowledges this violation and herein responds as follows: "The Company's procedure is to comply with this requirement. We believe this to be an isolated occurrence and not indicative of our normal processing standards. With respect to our accident business, the claim office turnaround time standards were amended to 10 business days in June 2003. This will assist in reducing undue delays and enable us to adhere to this requirement. This change will now permit a more timely response on all claims. We will continue to monitor this requirement in future claim audits.

**12. The Company attempted to settle a claim by making a settlement offer that was unreasonably low.** In one instance, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. The Department alleges this act to be in violation of CCR §2695.7(g).

**Summary of Company Response:** The Company acknowledges this violation and herein responds as follows: "The Company acknowledged this inadvertent error and will re-emphasize the importance of proper claim handling and continue to audit to ensure that proper benefit payments are made. The Case Manager made an inadvertent error which resulted in the claimant not receiving one day of benefits. The claimant was initially scheduled to return to work on July 29, 2002, and benefits were paid for the period of July 22, 2002 through July 28, 2002. However, the claimant actually returned to work on July 30, 2002, which differed from the original return to work date. This resulted in one additional day of benefits due to the claimant. Since the payments are normally generated through our claims adjudication system on an automatic schedule, it appears that the Case Manager inadvertently made an error by not going back into the system to generate the additional day of benefits due. The Company acknowledges this inadvertent error, issued the additional day of benefits in the amount of $17.14, as well as the appropriate interest payment in the amount of $1.58."